SUBMIT FORM

U.S. Department of Justice
United States Marshals Service

Complaint Regarding United States Marshals Service (USMS) Personnel or Programs

** Required Field*

Your Name: ROBERT W JOHNSON

Email Address: atemllc2023@gmail.com

Phone Number: 716-445-1734

Other Number: 716-445-1734

Street Address: 65 SIDNEY ST

City: BUFFALO

State: NEW YORK

ZIP Code: 14211

County: ERIE

[X] *** *I certify that the information contained herein is true and correct to the best of my knowledge.***

*** COMPLAINT DETAILS - Please provide a description of the facts and circumstances surrounding the reported activities, such as the evidence forming the basis of this report, the names of the individuals involved, dates, location, and their involvement:**

ROBERT W JOHNSON IS BEING DENIED RETAINER FEES AND INTEREST COSTS INCURRED FOR REPRESENTATION AND PROBES CONDUCTED FOR US DISTRICT COURT OF NEVADA CIVIL DOCKET NUMBER 2:15-CV-01045-RFB-BNW AND ROBERT W JOHNSON

RESERVES ALL RIGHTS TO AWARDS FOR JOB DUTIES RENDERED AND INTEREST FEES IN SETTLEMENT AGREEMENTS FOR ABOVE-SAID LEGAL MATTERS .

Privacy Act Statement: The USMS is authorized to collect this information from you pursuant to 28 C.F.R. § 0.111(n) and 28 C.F.R. § 0.113. The USMS will use the information you provide to investigate your complaint regarding USMS personnel and/or programs, and may contact you for more information. The information may be shared within the USMS, or to other components of the Department of Justice. In addition, the USMS may share the information with law enforcement agencies investigating a violation of law (whether criminal, civil, and/or administrative), or agencies implementing a statute, rule, or order. The contents of your complaint may be shared with Congressional offices. Additionally, the USMS may disclose relevant portions of the information to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide the requested information, but if you do not provide data in the fields listed, the USMS may not be able to properly address your complaint.

OMB Control Number 1105-0108 (Exp. 08/31/2023)

State of Nevada
Victims of Crime Program

Application for Victim of Crime Compensation

VOCP Date Stamp and Claim #

Please complete Sections 1 through 11 to the best of your ability. ***Use a black or blue ballpoint pen****.* Please Print Neatly.

Section 1: Tell us about the Victim.

The victim is the person who was attacked, injured or killed during the crime.

First Name, Middle Initial, Last Name			
ROBERT W JOHNSON			
Mailing Address	**City**	**State**	**Zip**
65 SIDNEY ST	BUFFALO	NY	14211
Cell Phone or Home Phone	**Work Phone**	**E-Mail**	
716-445-1734	716-445-1734	atemllc2023@gmail.com	
Date of Birth	**Age at time of crime**	**Last 4 Digits SSN**	
02/26/1984	38	9909	

[X] Male
[ ] Female

If victim is deceased, date of death: 03/22/2024

Section 2: If you are applying for the victim, tell us about you.

An applicant is a person, other than the victim, who is completing the application where the victim is under the age of 18, mentally or physically incapable of completing the application, or deceased.

First Name, Middle Initial, Last Name			
WILLIE JOHNSON			
Mailing Address	**City**	**State**	**Zip**
65 SIDNEY ST	BUFFALO	NY	14211
Cell Phone or Home Phone	**Work Phone**	**E-Mail**	
716-445-1734	716-445-1734	atemllc2023@gmail.com	

Relationship to victim:	Number of people requesting benefits	Last 4 Digits SSN	Date of Birth (applicant must be an adult)
	10000	9909	02/26/1984

Send Completed, Signed Applications to:

VOCP
6171 W. Charleston Blvd., Bldg. 9
Las Vegas, NV 89146
application@voc-net.com

Section 3: Tell us about the crime.

Please attach a copy of the police report prepared by the Law Enforcement Agency. *Claims submitted without a police report will be accepted and the VOCP will request a report. A decision will be made when the VOCP receives an official police report.*
Note: *Only Violent Crimes are eligible for VOCP assistance. No Theft or Property Crimes can be approved by the VOCP.*

Name of Law Enforcement Agency the crime was reported to:

LAS VEGAS POLICE DEPARTMENT

Date of Crime:	**Date Crime was Reported:**	**Crime Report No:**
07/13/2022	07/14/2022	22-9999

If Crime occurred more than two (2) years ago, please indicate why you did not apply to the VOCP until now:

- [X] Unaware of the VOCP
- [X] Physically/Mentally unable to apply
- [X] Other, explain:

LEGAL LITIGATIONS WERE PENDING .

Type of Victimization related to Crime if applicable: (Do not choose more than one)

- [X] Bullying
- [X] Domestic & Family Violence
- [X] Elder Abuse
- [X] Hate Crime
- [X] Mass Violence

Type of crime:

- [ ] Arson
- [X] Assault
- [ ] Burglary
- [ ] Child Physical Abuse/Neglect
- [ ] Child Pornography
- [ ] Child Sexual Abuse*
- [X] DUI/DWI
- [X] Fraud/Financial Crimes
- [ ] Homicide
- [ ] Human Trafficking
- [X] Kidnapping
- [X] Other Vehicular Crimes
- [X] Robbery
- [X] Sexual Assault*
- [X] Stalking
- [X] Terrorism
- [X] *Other:* WIRE FRAUD .

County where crime occurred:

- [X] Clark
- [ ] Carson City
- [ ] Churchill
- [ ] Douglas
- [ ] Elko
- [ ] Eureka
- [ ] Esmeralda
- [ ] Humboldt
- [ ] Lyon
- [ ] Lincoln
- [ ] Lander
- [ ] Mineral
- [ ] Nye
- [ ] Pershing
- [ ] Storey
- [ ] Washoe
- [ ] White Pine

Sexual Assault Crimes Only:
Required by: NRS 217.290 and NRS 217.300

Did you submit an application to the County for sexual assault assistance?

- [ ] Yes — If No: please explain:
- [X] No — THREATENED BY EMPLOYERS .

If Yes, have you received and/or exhausted those funds?

- [ ] Yes — If No: please explain:
- [X] No — PENDING.

Offender's Name and Address: (*if known*)

MARK S SHAPIRO AND PATRICK WHITESELL .

Where did the crime occur? (exact address, location, or nearest cross streets)

6650 S TORREY PINES DR : LAS VEGAS , NV 89118 .

Describe how the crime occurred:

ROBERT W JOHNSON WAS KIDNAPPED , ASSAULTED , SEXUALLY ASSAULTED AND MACED BY MARK S SHAPIRO AND PATRICK WHITESELL .

Describe victim's crime injuries:

HEAD , NECK , (R) ARM , BACK , SEXUAL ASSAULT , PTSD AND SHOCK OF CONSCIOUS .

Section 4: Tell us about your Crime Related Expenses

Please help us determine how we can help you. The VOCP has limited resources and we want to make sure the most important needs and financial issues are taken care of. Please ***check the crime related expenses you have incurred*** *or expect to incur because of the crime.* ***Attach your bills****, receipts, estimates, or other documents which support your request for payment.*
Expenses must be directly related to the crime and must have valid supporting documents to be paid by the VOCP.

- [X] Medical Bills
- [X] Ambulance Bills
- [X] Medical/Hospital Bills
- [X] Prescription Medication
- [X] Vision/Glasses
- [X] Chiropractic/Physical Therapy
- [X] Loss of Earnings/Survivor Benefits
- [X] Counseling/Mental Health
- [X] Funeral and Burial expense
- [X] Crime Scene Clean Up
- [X] Child Care Expenses
- [X] Relocation Expenses
- [X] Home Security Repairs
- [X] Home Health Care
- [X] *Other:* LEGAL .

Section 5: Tell us about any Prior Disabilities or Medical Conditions

If you suffered from any disabilities, or were receiving medical treatment prior to the crime, please explain below:

WORSENING OF CONDITIONS .

Section 6: Tell us about any Prior Victim of Crime Claims.

Have you ever filed a Victims of Crime Claim in Nevada, or any other State?

- [ ] Yes
- [X] No

If Yes: State where Claim Filed	Date filed	Type of Crime
n/a		

Name of Victim, Applicant, or Claimant	Current Status: (Opened or Closed)

Section 7: Please provide Demographic and Statistical Information

This information is gathered for statistical reporting purposes only. ***This information does NOT affect eligibility in any way.***

Annual Income:

- [ ] $0 to $10,000
- [ ] $10,000 to $20,000
- [ ] $20,000 to $30,000
- [ ] $30,000 to $40,000
- [ ] $40,000 to $60,000
- [ ] $60,000 to $80,000
- [ ] $80,000 to $100,000
- [X] Over $100,000

Employment at Time of Crime:

- [X] Employed
- [ ] Self-Employed
- [ ] Unemployed
- [ ] Retired
- [ ] *Other:*

Primary Language:

- [X] English
- [ ] Spanish
- [ ] Asian
- [ ] *Other*:

Were Alcohol or Drugs a factor in this crime, in any way?

- [X] Yes
- [ ] No
- [ ] Unknown

Race:

- [ ] American Indian/Alaska Native
- [ ] Asian
- [X] Black/African American
- [ ] Hispanic or Latino
- [ ] Native Hawaiian and Other Pacific Islander
- [ ] White Non-Latino/Caucasian
- [ ] Some Other Race
- [ ] Multiple Races

Marital Status:

- [X] Single
- [ ] Married
- [ ] Domestic Partners
- [ ] Divorced
- [ ] Widowed

Education Level:

- [ ] Less than High School Graduate
- [ ] High School Graduate or GED
- [ ] Attended College
- [X] Attended Graduate School/ University
- [ ] Have Advanced Degree

Section 8: How did you find out about the VOCP?

To help us evaluate and improve our services, please let us know how you heard of the VOCP. Please check one or two that apply.

- ☐ Law Enforcement
- ☐ District Attorney/Prosecutor
- ☐ Hospital/Clinic
- ☐ Medical/Dental Provider
- ☐ Children's Protective Services
- ☐ Mental Health Counselor
- ☐ Victim Advocate
- ☒ Victim Service Program (Safe Nest, Stop DUI, etc)
- ☐ Internet Search
- ☐ Newspaper/Media
- ☐ Friend/Family
- ☐ Other:

Section 9: Person helping the Applicant Complete this Application

Please complete the information below if you are helping the victim complete this application.

First Name	Last Name	Name of Company, Affiliation, or Relationship (Hospital, Dental Provider, Victim Program, etc):
WILLIE	JOHNSON	101 HANDS ON:65 SIDNEY ST:BUFFALO,NY 14211 .
Telephone: 716-445-1734	Email: atemllc2023@gmail.com	

Section 10: If an Advocate or Attorney is helping you, tell us about them

Complete this section if an attorney or victim advocate is assisting the victim. An advocate or attorney is not required in order to apply.

First Name	Last Name	Office Telephone
WILLIE	JOHNSON	716-445-1734

Office Address	City, State, Zip:
65 SIDNEY ST	BUFFALO , NY 14211
Victim Advocate Program or Law Firm Name: WILLIE JOHNSON LLP	Victim Advocate Email: atemllc2023@gmail.com

☒ *Upon request, please provide the above advocate or attorney with copies of correspondence sent to the Applicant.*

Signature of Advocate or Attorney: (Required to receive documents)	Date:
WILLIE JOHNSON	03/22/2024

Section 11: Tell us about the Victim's Insurance or Civil Suit Information

If you have any type of insurance or legal claim please enter the information in the space provided below. ***Use extra sheets if needed.***

Does the Victim/ Applicant have Life, Medical, Dental, or Vision Insurance? Please attach Insurance card.	If the crime involved an auto, does the Victim/ Applicant, or the Offender have Auto Insurance?	If the crime happened in Victim's home, or on Victim's property, is there Homeowners Insurance?	If the crime happened at the Victim/ Applicant's place of work, is there a Workers' Compensation
☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No

Company Name:	**Phone Number:**	**Type and Policy Number:**
PRUDENTIAL	PRUDENTIAL	PRUDENTIAL

Has the victim/applicant filed, or will the victim/applicant file, a Civil Suit related to this crime?	Has the victim/applicant received or expect to receive any payment or settlement related to the crime?
☒ Yes ☐ No ☐ Unknown	☒ Yes ☐ No ☐ Unknown

State of Nevada
Victims of Crime Program

Authorization for Release of Information, Certification and Acknowledgements:

Victim Name:	Victim DOB:	VOCP Claim #:
ROBERT W JOHNSON	02/26/1984	

I have filed an application with the Nevada Victims of Crime Compensation Program (VOCP). In order to assist the VOCP determine my eligibility I hereby consent to, and authorize the release of information to the VOCP. I hereby release and hold harmless anyone providing information to the VOCP from any liability for any such release.

Law Enforcement Reports: I hereby authorize any police, law enforcement agency, child protective agency, or Coroner's office to release any police, investigative, incident report, or coroner's report related to my application to the VOCP as required by: NRS 217.110 (2)(d), NRS 217.180, NRS 217.210 (1) and NRS 217.220 (1) and (2). I understand that all such reports will remain confidential as provided by State and Federal law and NRS 217.105.

Medical Information: I hereby authorize any hospital, medical clinic, physician, dentist, mental health provider, pharmacist, or any other medical provider to release any and all information including medical reports, histories, prognosis, treatment plans, billing information and any other information relating to my medical treatment for my crime related injuries or condition, to the VOCP as required by NRS 217.100. This information may be subject to re-disclosure and no longer protected by privacy rules. I have the right to revoke this authorization in writing at any time. *This Medical Authorization shall automatically expire without express revocation one year from the date below*. This release is in compliance with all HIPAA regulations. In order to continue to receive benefits past one year, an updated medical information release will be required.

VOCP Release of Information: I hereby authorize the VOCP to release information to police agencies, medical or other service providers, my advocate, attorney, or others concerning my application or claim only as necessary to administer the VOCP or my claim. No information will be released where prohibited by law. NRS 217.110 and 217.105.

Certificate of Financial Eligibility: I hereby certify that I do not have Savings or Investments exceeding the amount of my Annual Income, and that it would be a financial hardship if I were to receive no assistance from the VOCP. I hereby authorize any Insurer, Financial Institution, Government Agency, or any other person with information about me to release such information to the VOCP. NRS 217.220 (4).

My Promise to Repay the VOCP: I hereby acknowledge my legal obligation to repay the VOCP any money paid to me, or paid on my behalf, by the VOCP, ***if I receive any money, from any source, as a result of the crime.*** I hereby agree to notify the VOCP if I retain an Attorney to pursue a lawsuit or claim, or if I receive any court ordered restitution or other recovery including, but not limited to, insurance payments, settlements or other benefit payments. NRS 217.240.

Penalties for Providing False Information:

I understand that I may be imprisoned or fined for providing false or misleading, or intentionally incomplete information to the VOCP. I declare under Penalty of Perjury and pursuant to Nevada law that all the information I have provided is true, correct and complete to the best of my information and belief. NRS 217.270.

Print Full Name of Person Signing Application:	WILLIE JOHNSON
Signature of Victim/Applicant (must be signed by an adult) ROBERT W JOHNSON	***Date:*** 03/22/2024

Send Completed, Signed Applications to:

VOCP
6171 W. Charleston Blvd., Bldg. 9
Las Vegas, NV 89146

Scan *and E-Mail to:* application@voc-net.com *Fax to: (702) 486-2825*

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer TKO GROUP HOLDINGS , INC 92-3569035

Name of Employee	Social Security Number	Telephone Number
ROBERT W JOHNSON:65 SIDNEY ST: BUFFALO,NY 14211 .	076-78-9909	716-445-1734

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
07/13/2022	07:00pm	6650 S TORREY PINES DR:LAS VEGAS , NV 89118 .

What is the nature of the injury or occupational disease?	List any body parts involved:
HEAD,NECK,(R) ARM,BACK,ASSAULT,PTSD AND SHOCK OF CONSCIENCE.	MULTIPLE BODY PARTS.

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)
ROBERT W JOHNSON WAS KIDNAPPED , POISONED , ASSAULTED AND SEXUALLY ASSAULTED BY MARK S SHAPIRO AND PATRICK WHITESELL >

Names of witnesses:
PENDING.

Did the employee leave work because of the injury or occupational disease? X YES ___ NO	If yes, when (date and time)? 07/13/2022	Has the employee returned to work? ___ YES ___ NO	If yes, when (date and time)? PENDING.
Was first aid provided? ___ YES X NO	If yes, by whom?	Name and address of treating physician, if applicable or known pending.	
Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO			
Was anyone else involved? X YES ___ NO	Names of others involved MARK S SHAPIRO AND PATRICK WHITESELL .		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

EGON P DURBAN	03/20/2024	ROBERT W JOHNSON	03/20/2024
Supervisor's Signature	Date	Signature of Injured or Disabled Employee	Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA/ E-mail: cha@govcha.nv.gov

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 02/20)